

## **Expedited Authorization Codes and Criteria Table**

| <b>Drug</b>                                    | <b>Code</b> | <b>Criteria</b>   |
|--|-------------|---|
| <b>90-day supply required</b>                  | 090         | The prescription is written for less than a 90-day supply.  |
| <b>Abilify® IM injection</b><br>(aripiprazole) | 065         | All of the following must apply:<br><br>a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder;<br>b) Patient is 18 to 65 years of age; and<br>c) Maximum dose of 30 mg in a 24 hour period.  |
| <b>Accutane®</b><br>(isotretinoin)             |             | <del>Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be absent:</del><br><del>a) Paraben sensitivity;</del><br><del>b) Concomitant tretinate therapy; and</del><br><del>c) Hepatitis or liver disease.</del> |
|  | <b>001</b>  | <del>Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.</del>   |
|  | <b>002</b>  | <del>Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.</del>   |
|  | <b>003</b>  | <del>Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.</del>   |
|  | <b>004</b>  | <del>Prevention of skin cancers in patients with xeroderma pigmentosum.</del>   |
|  | <b>005</b>  | <del>Diagnosis of mycosis fungoides (T cell lymphoma) unresponsive to other therapies.</del>  |
| <b>Aggrenox® (aspirin/dipyridamole)</b>        | 037         | To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and have no sensitivity to aspirin.   |
| <b>Aloxi® Injection</b><br>(palonosetron)      | 129         | Administered as a single dose in conjunction with cancer chemotherapy treatment.  |

## Prescription Drug Program

| Drug  | Code | Criteria   |
|---|------|--|
| <b>Ambien®</b><br>( <i>zolpidem tartrate</i> )    | 006  | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.  |
| <b>Ambien CR®</b><br>( <i>zolpidem tartrate</i> ) | 006  | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.  |
| <b>Amevive®</b> ( <i>alefacept</i> )              | 018  | Treatment of plaque psoriasis when prescribed by a rheumatologist or dermatologist in patients who are candidates for systemic or phototherapy. Maximum dose of 7.5mg intravenous bolus or 15mg intramuscular injection once a week. |
| <b>Amitiza®</b><br>( <i>lubiprostone</i> )        | 007  | Treatment of chronic constipation. Must have tried and failed a less costly alternative.   |

## Prescription Drug Program

| Drug  | Code | Criteria  |
|---|------|---|
| <b>Angiotensin Receptor Blockers (ARBs)</b><br><br><b>Atacand®</b> ( <i>candesartan cilexetil</i> )<br><b>Atacand HCT®</b> ( <i>candesartan cilexetil/HCTZ</i> )<br><b>Avalide®</b> ( <i>irbesartan/HCTZ</i> )<br><b>Avapro®</b> ( <i>irbesartan</i> )<br><b>Benicar®</b> ( <i>olmesartan medoxomil</i> )<br><b>Benicar HCT®</b> ( <i>olmesartan medoxomil/HCTZ</i> )<br><b>Cozaar®</b> ( <i>losartan potassium</i> )<br><b>Diovan®</b> ( <i>valsartan</i> )<br><b>Diovan HCT®</b> ( <i>valsartan/HCTZ</i> )<br><b>Hyzaar®</b> ( <i>losartan potassium/HCTZ</i> )<br><b>Micardis®</b> ( <i>telmisartan</i> )<br><b>Micardis HCT®</b> ( <i>telmisartan/HCTZ</i> )<br><b>Teveten®</b> ( <i>eprosartan mesylate</i> )<br><b>Teveten HCT®</b> ( <i>eprosartan mesylate/HCTZ</i> ) | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.                                  |
| <b>Anzemet®</b> ( <i>dolasetron mesylate</i> )  | 127  | Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.   |
| <b>Arava®</b> ( <i>leflunomide</i> )  | 034  | Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter. |

## Prescription Drug Program

| Drug  | Code | Criteria  |
|---|------|---|
| <b>Atacand®</b> ( <i>candesartan cilexetil</i> )  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Atacand HCT®</b> ( <i>candesartan cilexetil/HCTZ</i> )   | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Atypical Antipsychotics (Generics First)</b><br><br><b>Abilify®</b> ( <i>aripiprazole</i> )<br><b>Geodon®</b> ( <i>ziprasidone HCl</i> )<br><b>Geodon®</b> ( <i>ziprasidone mesylate</i> ) IM<br><b>Invega™</b> ( <i>paliperidone</i> )<br><b>Risperdal®</b> ( <i>risperidone</i> )<br><b>Risperdal Consta®</b> ( <i>risperidone</i> )<br><b>Seroquel®</b> ( <i>quetiapine</i> ) /XR<br><b>Zyprexa®</b> ( <i>olanzapine</i> ) /<br><b>Zydis®</b><br><b>Zyprexa®</b> ( <i>olanzapine</i> )<br><b>Clozaril®</b> ( <i>clozapine</i> )<br><b>Fanapt®</b> ( <i>iloperidone</i> )<br><b>Invega Sustenna®</b> ( <i>paliperidone</i> )<br><b>Risperdal®</b> ( <i>risperidone</i> )<br><b>Saphris®</b> ( <i>asenapine</i> ) | 400  | Continuation of therapy.  |
|   | 401  | Client is not a new start.  |
|   | 402  | History of hyperprolactinemia.  |
|   | 403  | History of extrapyramidal symptoms (EPS).   |
|   | 404  | Pharmacy has chart note on file documenting client's refusal of a generic atypical antipsychotic, or their request for a specific atypical antipsychotic.                       |
|   | 405  | Prescribed for a diagnosis which is not FDA indicated for any preferred generic AAP.  |
|   | 406  | Patient in Crisis.  |
| <b>Avalide®</b> ( <i>irbesartan/HCTZ</i> )  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Avapro®</b> ( <i>irbesartan</i> )  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Avinza®</b> ( <i>morphine sulfate</i> )  | 040  | Diagnosis of cancer-related pain.   |
| <b>Azor®</b> ( <i>amlodipine/olmesartan</i> )   | 093  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium |

## Prescription Drug Program

| Drug   | Code | Criteria  |
|--|------|---|
|  |      | channel blocker and/or angiotensin receptor blocker (ARB) therapy.  |
| <b>Benicar®</b> ( <i>olmesartan medoxomil</i> )          | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Benicar HCT®</b> ( <i>olmesartan medoxomil/HCTZ</i> ) | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Blood Glucose Test Strips</b>                         | 263  | Gestational Diabetes (up to two months post delivery)   |
|  | 264  | Insulin-dependent diabetic (age 21 and older)   |
|  | 265  | Insulin-dependent diabetic (age 20 and younger)   |
|  | 266  | Client had diabetes prior to pregnancy  |
| <b>bupropion/SR/XL</b>                                   | 014  | Not for smoking cessation.  |
| <b>Campral®</b> ( <i>acamprosate sodium</i> )            | 041  | <p>Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment;</li> <li>b) Must not be a poly-substance abuser; and</li> <li>c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min).</li> </ul> <p><b>Note:</b> A Campral authorization form, DSHS 13-749, must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to:<br/> <a href="http://www1.dshs.wa.gov/msa/forms/eforms.html">http://www1.dshs.wa.gov/msa/forms/eforms.html</a>.</p> |
| <b>Celebrex®</b> ( <i>celecoxib</i> )                    | 062  | <p>All of the following must apply:</p> <ul style="list-style-type: none"> <li>a) An absence of a history of ulcer or gastrointestinal bleeding; and</li> <li>b) An absence of a history of cardiovascular disease.</li> </ul>  |
| <b>Copegus®</b> ( <i>ribavirin</i> )                     | 010  | Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).   |

**Prescription Drug Program**

| <b>Drug</b>   | <b>Code</b> | <b>Criteria</b>  |
|---|-------------|--|
| <b>Cozaar®</b> ( <i>losartan potassium</i> )  | 092         | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.   |
| <b>Cymbalta®</b> ( <i>duloxetine</i> )  | 163         | Treatment of <b>diabetic</b> peripheral neuropathy.  |
|   | 166         | Treatment of fibromyalgia.   |
| <b>Diovan®</b> ( <i>valsartan</i> )   | 092         | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.   |
| <b>Diovan HCT®</b> ( <i>valsartan/HCTZ</i> )  | 092         | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.   |
| <b>Dolophine®</b> ( <i>methadone HCl</i> )  | 040         | Diagnosis of cancer-related pain.  |
| <b>Duragesic®</b> ( <i>fentanyl</i> )   | 040         | Diagnosis of cancer-related pain.  |
| <b>Enbrel®</b> ( <i>etanercept</i> )  | 017         | Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).   |
|   | 024         | Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.  |
|   | 025         | Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.                                  |
|   | 026         | Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients ages 2 and older who have had an inadequate response to one or more DMARD. Dose not to exceed 0.8 mg/kg subcutaneously per week and/or 50 mg per week. |
| <b>Exforge®</b> ( <i>amlodipine/valsartan</i> )<br><b>Exforge® HCT</b> ( <i>amlodipine/ valsartan/ HCTZ</i> ) | 093         | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.   |

## Prescription Drug Program

| Drug  | Code | Criteria   |
|---|------|--|
| <b>Exelon®</b><br><b>capsules/patch</b><br><b>/solution</b><br>( <i>rivastigmine</i> )  | 015  | Treatment of mild to moderate dementia associated with Parkinson's disease   |
| <b>Gabitril®</b><br>( <i>tiagabine HCl</i> )  | 036  | Treatment of seizures.   |
| <b>Geodon® IM</b><br><b>Injection</b><br>( <i>ziprasidone mesylate</i> )  | 058  | All of the following must apply:<br><br>a) Diagnosis of acute agitation associated with schizophrenia;<br>b) Patient is 18 years of age or older; and<br>c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment. |
| <b>Note:</b> Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval. |      |  |
| <b>Glycolax</b><br><b>Powder®</b><br>( <i>polyethylene glycol</i> )   | 024  | <del>Treatment of occasional constipation. Must have tried and failed a less costly alternative.</del>   |

## Prescription Drug Program

| Drug  | Code | Criteria   |
|---|------|--|
| <b>Humira®</b> ( <i>adalimumab</i> )              | 022  | Treatment of Crohn's disease when prescribed by a gastroenterologist for patients who have tried and failed conventional therapy. 160mg subcutaneous dose to start, 80mg at week 2, and then maximum dose of 40mg subcutaneously every other week.   |
|   | 023  | Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD). Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.   |
|   | 028  | Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have had an inadequate response to one or more DMARD. Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.  |
|   | 056  | Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Maximum dose is 40mg subcutaneously every other week after the initial single 80mg loading dose.   |
|   | 061  | Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients age 4 years and older who have had an inadequate response to one or more DMARD. Maximum dose is 20mg subcutaneously every other week in patients weighing 15kg to <30kg, and 40mg every other week in patients weighing ≥30kg. |
| <b>Hyzaar®</b> ( <i>losartan potassium/HCTZ</i> ) | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.   |
| <b>Infergen®</b> ( <i>interferon alfacon-1</i> )  | 134  | Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.   |



## Prescription Drug Program

| Drug  | Code       | Criteria  |
|---|------------|---|
| <b>Intron A®</b><br>(interferon<br>alpha-2b<br>recombinant) | 030        | Diagnosis of hairy cell leukemia in patients 18 years of age and older.   |
|   | 031        | Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.  |
|   | 032        | Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.   |
|   | 033        | Diagnosis of chronic hepatitis B in patients 1 year of age and older.   |
|   | 107        | Diagnosis of malignant melanoma in patients 18 years of age and older.  |
|   | 109        | Treatment of chronic hepatitis C in patients 18 years of age and older.   |
|   | 135        | Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.   |
| <b>isotretinoin</b>   |            | Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be <b>absent</b> :<br>a) Paraben sensitivity;<br>b) Concomitant tretinate therapy; and<br>c) Hepatitis or liver disease. |
|   | <b>001</b> | Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.  |
|   | <b>002</b> | Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.  |
|   | <b>003</b> | Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.  |
|   | <b>004</b> | Prevention of skin cancers in patients with xeroderma pigmentosum.  |
|   | <b>005</b> | Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.   |

**Prescription Drug Program**

| <b>Drug</b>   | <b>Code</b> | <b>Criteria</b>   |
|---|-------------|---|
| <b>Kadian®</b><br>( <i>morphine sulfate</i> )                 | 040         | Diagnosis of cancer-related pain.   |
| <b>Keppra® /XR</b><br>( <i>levetiracetam</i> )                |             | See criteria for Gabitril®.   |
| <b>Kineret® Injection</b><br>( <i>anakinra</i> )              | 029         | Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.  |
| <b>Kytril®</b><br>( <i>granisetron HCl</i> )                  | 127         | Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.   |
|   | 128         | Prevention of nausea or vomiting associated with radiation therapy.   |
| <b>Lamictal®</b> ( <i>lamotrigine</i> )                       | 083         | Treatment of epilepsy/seizures  |
|   | 084         | Treatment of Bipolar Disorder   |
| <b>Lamisil®</b><br>( <i>terbinafine HCl</i> )                 |             | Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:   |
|   | 042         | Diabetic foot;  |
|   | 043         | History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;   |
|   | 051         | Peripheral vascular disease; or   |
|   | 052         | Patient is immunocompromised.   |
| <b>lamotrigine</b>  | 083         | Treatment of epilepsy/seizures  |
|   | 084         | Treatment of Bipolar Disorder   |
| <b>Lancets</b>  | 263         | Gestational Diabetes (up to two months post delivery)   |
|   | 264         | Insulin-dependent diabetic (age 21 and older)   |
|   | 265         | Insulin-dependent diabetic (age 20 and younger)   |
|   | 266         | Client had diabetes prior to pregnancy  |
| <b>levetiracetam</b>  | 036         | Treatment of seizures.  |
| <b>Levorphanol</b>  | 040         | Diagnosis of cancer-related pain.   |
| <b>Lotrel®</b><br>( <i>amlodipine- besylate/ benazepril</i> ) | 038         | Treatment of hypertension as a second-line agent when blood pressure is not controlled by any:<br>a) ACE inhibitor alone; or<br>b) Calcium channel blocker alone; or<br>c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions. |

## Prescription Drug Program

| Drug  | Code | Criteria  |
|---|------|---|
| <b>Lunesta™</b><br>( <i>eszopiclone</i> )   | 006  | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills. |
| <b>Lyrica®</b> ( <i>pregabalin</i> )  | 035  | Treatment of post-herpetic neuralgia.   |
|   | 036  | Treatment of seizures.  |
|   | 063  | Treatment of diabetic peripheral neuropathy.  |
|   | 066  | Treatment of fibromyalgia.  |
| <b>Micardis®</b><br>( <i>telmisartan</i> )  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.      |
| <b>Micardis HCT®</b><br><i>telmisartan/HCTZ</i> )   | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.      |
| <b>Miralax®</b><br>( <i>polyethylene glycol</i> )   |      | See criteria for Glycolax Powder®.  |
| <b>MS Contin®</b><br>( <i>morphine sulfate ER</i> )   | 040  | Diagnosis of cancer-related pain.   |
| <b>Naltrexone</b>   |      | See criteria for ReVia®.  |
| <b>Nephrocaps®, Nephro-Fer®, Nephro-vite®, Nephro-Vite® Rx, Nephro-vite® +Fe, and Nephron® FA</b> | 096  | Treatment of patients with renal disease.   |
| <b>Neurontin®</b><br>( <i>gabapentin</i> )  | 035  | Treatment of post-herpetic neuralgia.   |
|   | 036  | Treatment of seizures.  |
|   | 063  | Treatment of diabetic peripheral neuropathy.  |

| Drug   | Code | Criteria   |
|--|------|--|
| <b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b><br><br><b>Arthrotec®</b><br><i>(diclofenac/misoprostol)</i><br><b>Cambia™</b> <i>(diclofenac potassium)</i><br>diclofenac potassium<br>diclofenac sodium<br>SR/ER/EC<br>diflunisal<br>etodolac /ER<br>fenoprofen<br><b>Flector®</b> <i>(diclofenac epolamine)</i><br>flurbiprofen<br>ibuprofen<br>ibuprofen/hydrocodone<br><b>(Vicoprofen®)</b><br>indomethacin /SR<br>ketoprofen /SR<br>ketorolac<br>meclofenamate<br>meloxicam<br>nabumetone<br>naproxen /EC<br>naproxen sodium /ER<br>oxaprozin<br>piroxicam<br><b>Ponstel®</b> <i>(mefenamic acid)</i><br>salsalate<br>sulindac<br>tolmetin<br><b>Voltaren®</b> <i>(diclofenac sodium)</i> gel | 141  | An absence of a history of ulcer or gastrointestinal bleeding. |

## Prescription Drug Program

| Drug  | Code | Criteria   |
|---|------|--|
| <b>Opana ER®</b><br>( <i>Oxymorphone HCl ER</i> ) | 040  | Diagnosis of cancer-related pain.  |
| <b>Orencia®</b> ( <i>abatacept</i> )              | 044  | Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Maintenance dose is limited to 1000mg as an intravenous infusion every 4 weeks after the initial 4 weeks of therapy (allowed to be dosed every 2 weeks during first 4 weeks of therapy). |
| <b>Oxandrin®</b><br>( <i>oxandrolone</i> )        |      | Before any code is allowed, there must be an absence of all of the following:<br><br>a) Hypercalcemia;<br>b) Nephrosis;<br>c) Carcinoma of the breast;<br>d) Carcinoma of the prostate; and<br>e) Pregnancy.   |
|   | 110  | Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.  |
|   | 111  | To compensate for the protein catabolism due to long-term corticosteroid use.  |
|   | 112  | Treatment of bone pain due to osteoporosis.  |
| <b>OxyContin®</b><br>( <i>oxycodone HCl</i> )     | 040  | Diagnosis of cancer-related pain.  |
| <b>Parcopa®</b><br>( <i>carbidopa/levodopa</i> )  | 049  | Diagnosis of Parkinson's disease and one of the following:<br>a) Must have tried and failed generic carbidopa/levodopa;<br>or<br>b) Be unable to swallow solid oral dosage forms.  |

## Prescription Drug Program

| Drug  | Code | Criteria   |
|---|------|--|
| <b>Plavix®</b><br>( <i>clopidogrel bisulfate</i> )                                | 116  | When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.  |
|   | 136  | For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy. |
| <b>Prevacid®</b><br><b>SoluTab™</b><br>( <i>lansoprazole</i> )                    | 050  | Inability to swallow oral tablets or capsules.   |
| <b>Pulmozyme®</b><br>( <i>dornase alpha</i> )                                     | 053  | Diagnosis of cystic fibrosis and the patient is 5 years of age or older.   |
| <b>Ramipril</b>   | 020  | Patients with a history of cardiovascular disease.   |
| <b>Rebetol®</b><br>( <i>ribavirin</i> )   |      | See criteria for Copegus®.   |
| <b>Rebetron®</b><br>( <i>ribavirin/interferon alpha-2b, recombinant</i> )         | 008  | Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.  |
|   | 009  | Treatment of chronic hepatitis C in patients with compensated liver disease.   |
| <b>Remicade Injection®</b><br>( <i>infliximab</i> )                               | 046  | Treatment of ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum maintenance dose is 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy.  |
| <b>Rena-Vite®</b><br><b>Rena-Vite RX®</b><br>( <i>folic acid/vit B comp W-C</i> ) | 096  | Treatment of patients with renal disease.  |

## Prescription Drug Program

| Drug   | Code | Criteria  |
|--|------|---|
| <b>ReVia®</b><br>( <i>naltrexone HCl</i> )   | 067  | <p>Diagnosis of past opioid dependency or current alcohol dependency.</p> <p>Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:</p> |
|  |      | <p>a) Acute liver disease; and</p> <p>b) Liver failure; and</p> <p>c) Pregnancy.</p>  |
| <p><b>Note:</b> A ReVia® (<i>Naltrexone</i>) Authorization Form, DSHS 13-677, must be on file with the pharmacy before the drug is dispensed. <b>To download a copy, go to:</b><br/> <a href="http://www1.dshs.wa.gov/msa/forms/eforms.html">http://www1.dshs.wa.gov/msa/forms/eforms.html</a></p> |      |   |
| <b>Ribavirin</b>   |      | See criteria for Copegus®.  |
| <b>Risperdal®</b><br><b>Consta® IM</b><br><b>Injection</b><br>( <i>risperidone microspheres</i> )  | 059  | <p>All of the following must apply:</p> <p>a) There is an appropriate DSM IV diagnosis with a psychotic disorder;</p> <p>b) Patient is 18 to 65 years of age;</p> <p>c) Patient has established tolerance to oral risperidone prior to initiating Risperdal Consta®; and</p> <p>d) Total daily dose is not more than 9mg/day (injectable plus oral at an injectable conversion rate of 25 mg every two weeks IM = 2 mg every day oral).</p>   |
| <b>Rituxan®</b> ( <i>rituximab</i> )   | 054  | Treatment of non-Hodgkin's lymphoma.  |
|  | 055  | Treatment of rheumatoid arthritis when prescribed by a rheumatologist in combination with methotrexate in patients who have failed another tumor necrosis factor (TNF) inhibitor. Limited to 2 1000mg intravenous infusions separated by 2 weeks.   |

## Prescription Drug Program

| Drug   | Code | Criteria   |
|--|------|--|
| <b>Roferon-A®</b><br>(interferon alpha-2a recombinant) | 030  | Diagnosis of hairy cell leukemia in patients <b>18</b> years of age and older.   |
|  | 032  | Diagnosis of AIDS-related Kaposi's sarcoma in patients <b>18</b> years of age and older.   |
|  | 080  | Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.  |
|  | 109  | Treatment of chronic hepatitis C in patients <b>18</b> years of age and older.   |
| <b>Savella®</b> (milnacipran HCl)                      | 066  | Treatment of fibromyalgia.   |
| <b>Sonata®</b><br>(zaleplon)                           | 006  | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.  |
| <b>Soriatane®</b><br>(acitretin)                       | 064  | Treatment of severe, recalcitrant psoriasis in patients <b>16</b> years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an <b>absence</b> of all of the following:<br><br>a) Current pregnancy or pregnancy which may occur while undergoing treatment; and<br>b) Hepatitis; and<br>c) Concurrent retinoid therapy. |
| <b>Sporanox®</b><br>(itraconazole)                     |      | Must not be used for a patient with cardiac dysfunction such as congestive heart failure.  |
|  | 047  | Treatment of systemic fungal infections and dermatomycoses.  |
|  |      | Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:  |
|  | 042  | Diabetic foot;   |
|  | 043  | History of cellulitis secondary to onychomycosis <b>and</b> requiring systemic antibiotic therapy;   |
|  | 051  | Peripheral vascular disease; <b>or</b>   |
|  | 052  | Patient is immunocompromised.  |



## Prescription Drug Program

| Drug  | Code | Criteria  |
|---|------|---|
| <b>Talacen®</b><br><i>(pentazocine HCl/acetaminophen)</i><br><br><b>Talwin NX®</b><br><i>(pentazocine/naloxone)</i> | 091  | Patient must be <b>12</b> years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.   |
| <b>Teveten®</b> <i>(eprosartan mesylate)</i>  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Teveten HCT®</b><br><i>(eprosartan mesylate/HCTZ)</i>  | 092  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.  |
| <b>Topamax®/Topamax® Sprinkle</b><br><i>(topiramate)</i>  | 036  | Treatment of Seizures.  |
|   | 045  | Migraine prophylaxis.   |
| <b>Twynsta®</b> <i>(amlodipine/telmisartan)</i>   | 093  | Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.                                      |
| <b>Vancomycin oral</b>  | 069  | Diagnosis of clostridium difficile toxin and one of the following:<br><br>a) The patient has failed to respond after 2 days of metronidazole treatment; or<br>b) The patient is intolerant to metronidazole; or<br>c) Metronidazole is contraindicated due to drug-drug interaction(s). |
| <b>Wellbutrin SR® and XL®</b><br><i>(bupropion HCl)</i>   | 014  | Not for smoking cessation.  |
| <b>Zaleplon</b>   | 006  | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.   |
| <b>Zofran®</b><br><i>(ondansetron HCl)</i>  |      | See criteria for Kytril®.   |

**Prescription Drug Program**

| <b>Drug</b>  | <b>Code</b> | <b>Criteria</b>   |
|--|-------------|---|
| <b>Zolpidem</b>  | 006         | Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.   |
| <b>Zometa®</b><br>(zoledronic acid)                    | 011         | Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.   |
| <b>Zyprexa®</b><br><b>IM Injection</b><br>(olanzapine) | 060         | All of the following must apply:<br><br>a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder;<br>b) Before any subsequent doses are given, patient has been evaluated for postural hypotension and no postural hypotension is present;<br>c) Patient is 18 to 65 years of age; and<br>d) Maximum dose of 30 mg in a 24 hour period. |
| <b>Zyvox®</b><br><b>Injectable</b><br>(linezolid)      | 013         | Treatment of vancomycin resistant infection.  |
| <b>Zyvox®</b><br><b>Oral</b><br>(linezolid)            | 013         | Treatment of vancomycin resistant infection   |
|  | 016         | Outpatient treatment of methacillin resistant staph aureus (MRSA) infections when IV vancomycin is contraindicated, such as:<br><br>a) Allergy; or<br>b) Inability to maintain IV access.   |